Pediatric Dentistry

The information below must be filled out completely by a legal parent or guardian. If you do not have the legal right to fill out this form, please inform the front desk. Please fill out the form completely or put an N/A if not applicable.All communications regarding billing, appointments, etc. will go to the person filling out this form.

Date _____

Name of person filling out this form:_____

Phone number of person filling out this form:_____

***This phone number will be used for all office communications including but not limited to billing, appointment reminders etc.**

Relationship to child(ren)_____

FAMILY INFORMATION SHEET

Child(ren)'s names(s) _____ _____

_____ _____

_____ _____

_____ _____

PARENTAL/GUARDIAN INFORMATION

Marital Status of Parents/Guardians: ☐ Married ☐ Divorced ☐ Single ☐ Other

Father's Name_____
E-mail Address _____
Birth date ____/____/____
Mailing Address_____
City _____State_____Zip_____
Cell Phone # _____
Social Security # _____
Employer _____
Employer's Phone # _____
Employer's Address _____

Mother's Name_____
E-mail Address: _____
Birth date____/____/____
Mailing Address_____
City_____State_____Zip_____
Cell Phone #_____
Social Security #_____
Employer _____
Employer's Phone #_____
Employer's Address _____

INSURANCE INFORMATION

***If correct insurance information is not provided before the appointment, any balance owed will become patient/parent responsibility.**

Primary Dental Insurance Info.
Insurance Company_____
Policyholder _____
Policyholder's date of birth_____
ID # _____

Secondary Dental Insurance Info.(if applicable)
Insurance Company_____
Policyholder_____
Policyholder's date of birth_____
ID # _____

EMERGENCY INFORMATION

Person to contact in case of emergency _____
Address _____
Phone #_____ Relationship_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

By signing this form you are taking responsibility for your child's account with this office and any charges incurred from provided services. The person filling out this form must be the same as signing.

Printed Name of Parent/Guardian:_____Relationship:_____
Signed: _____ Date: _____
In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services. All communications regarding billing, appointments, etc. will go to the person filling out this form.

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. The adult that accompanies any minor to their appointment is responsible for any payment due. For unaccompanied minors, treatment will need to be prepaid or payment sent with the minor in order for treatment to be rendered. In a divorce situation, the parent or guardian that signed the original paperwork will be considered financially responsible. We are unable to send a bill to the other party, split bills between parents or be a part of billing disputes between divorced parents.
Our office may utilize text and email billing services. By providing my cell phone number and/or email I am agreeing to receive text and/or email communications unless I opt out by contacting ABC Pediatric Dentistry.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. I assign my payable dental insurance benefits to ABC Pediatric Dentistry. If ABC Pediatric Dentistry has not received payment from the insurance provided within 60 days from the submission of a claim, I agree to pay for all dental services in full.

A fee of $20 per patient will be charged for appointments changed or canceled without a minimum 24 hour notice. This fee will need to be paid in full before another appointment is scheduled. We reserve the right to excuse patients from the practice if there are unreasonable amounts of missed or canceled appointments or for any other reason we deem necessary.

A service charge of 2 % per month (20% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. A $30 fee will be charged on all returned checks or debits.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to paid dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay all costs and reasonable attorney fees to collect monies owed by me, including interest charges, processing fees, collection costs/commissions (up to 40% of total due) that may be assessed by any collection agency retained to pursue this matter. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designers to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this and all forms accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of Parent, or Guardian Date Relationship to Patient(s)

Pediatric Dentistry

CONSENT TO PROCEED:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Stanton C. Allen, DDS, Brandon J. Nakken, DDS, Brandi Oberg, DDS, and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor(s) or other individual(s) for which I have responsibility, now and in the future, including arrangement and/or administration of any sedation (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of the treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in very rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand that this situation is atypical.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child/children or ward(s). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature_____ Date_____
(Legal guardian or authorized agent of patient(s)

Patient HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that ABC Pediatric Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact them as the above address to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revise this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name(s): _____

Signature of Patient or Parent Representative _____

Relationship to patient (if minor): _____

Pediatric Dentistry

ABC Pediatric Dentistry Policies

We appreciate the opportunity to provide dental care for your child. Because we value our relationship with you and appreciate your trust in us we offer these clarifications of our policies for your understanding and benefit.

- At each basic 6 month appointment we provide the Standard of Care set up by the American Dental Association, which is a Prophy(cleaning), Fluoride, Exam and X-rays, which may include periapical, bitewing and/or panorex. If your insurance plan does not cover the benefits of Standard of Care every 6 months, it is your responsibility to let us know. If any service is denied you are responsible for any charges incurred.
- We require a parent or legal guardian to be present for all minor children's dental appointments.
- If Nitrous Oxide (laughing gas) is used we require the fee to be paid on the date of service.
- We require any estimates from your insurance plan to be paid in full on the date of service. However, you understand this is a generalized estimate only and you may be billed for additional charges after we receive reimbursement from your insurance plan. Your insurance determines what your final cost is and we bill accordingly.
- We will be happy to file insurance claims on your behalf as long as we have received accurate insurance information. Insurance information must be provided on the date of service in order to be billed. Claims will not be backdated so accurate information is required before the patient can be seen. If we are unable to verify active coverage or insurance information is not provided, charges will be required to be paid in full on the date of service. If you carry a secondary/tertiary policy it is your responsibility to know which plan is primary, secondary and tertiary. If you do not know that information, we are unable to bill correctly and will require payment in full from the guarantor for any services rendered.
- Any secondary/tertiary insurance coverage must also be provided on the date of service. If secondary/tertiary insurance is not provided on the date of service we are unable to bill the claim to the secondary/tertiary insurance carrier but will be happy to bill for any future appointments once we have received the information.
- Your insurance is a contract between you and your insurance carrier, therefore, it is your responsibility to know and understand your coverage and benefits. Any amount that insurance does not pay is your responsibility. This includes, but is not limited to, deductibles, co-pays, denied charges and non-covered procedures. Please understand that insurance companies never guarantee payment and that all charges incurred in this office are ultimately your responsibility.
- We cannot become involved in prolonged insurance negotiations, therefore if payment has not been received from your insurance company within 60 days any charges incurred in our office will become your responsibility.
- Any charges not paid in full or not in an official payment plan set up by our accounts department within 90 days from the first bill sent to you will be referred to a collections agency. You agree and understand that you will be responsible to pay a collection agency fee of 40% on any unpaid balance and are responsible for all costs associated with collection, including, but not limited to attorney fees and court costs and any/all other fees charged.
- Supplemental and reimbursement plans are required to be paid in full on the date of service and it is the responsibility of the subscriber to submit any/all applicable paperwork to their supplemental/reimbursement plan policy.
- The adult that accompanies any minor to their appointment is responsible for any payment due. For unaccompanied minors, treatment will need to be prepaid or payment sent with the minor in order for treatment to be rendered. In a divorce situation, the parent or guardian that signed the original paperwork will be considered financially responsible. We are unable to send a bill to the other party, split bills between parents or be a part of billing disputes between divorced parents.
- A fee of $20 per patient will be charged for appointments changed or canceled without a minimum 24 hour notice. This fee will need to be paid in full before another appointment is scheduled. We reserve the right to excuse patients from the practice if there are unreasonable amounts of missed or canceled appointments.
- Text and/or email billing may be utilized by our office. The number listed in the file as the guarantor will receive billing and/or email communications. Communication is vital to our office, therefore, by providing your phone number you are agreeing to communications via calls and/or text messaging. To opt out you must contact ABC Pediatric Dentistry.

I have read and understand the above policies and agree to abide by its contents. If requested a copy of all forms will be provided.

SIGNATURE _____ DATE _____

ABC Pediatric Dentistry - Patient Information

Patients Full Legal Name:_____
Patients Preferred Name (if different than legal name):_____
Patient's Birthday_____
☐ Male ☐ Female ☐Non-Binary
Does the patient speak English? ☐ Yes ☐ No If no, primary language spoken? _____

Name of person completing this form_____
Are you the child's legal guardian? ☐YES ☐NO
Relationship to Patient: ☐ Mother ☐ Father ☐ Step-parent ☐ Other(Explain) _____
Patient primarily lives with ☐ Both Parents ☐ Mother ☐ Father ☐ Other(Explain) _____

DENTAL HISTORY

Is this the patient's first dental visit☐ No☐ Yes; Date of last visit_____
Reason for today's visit_____
Is the patient in pain☐ Yes ☐ No If yes: Explain_____

Has the patient ever had any of the following:

YES	NO		YES	NO	
☐	☐	Thumb or finger sucking, nail biting, etc.	☐	☐	Grinding or clenching of teeth
☐	☐	Pacifier, bottle in bed	☐	☐	Fluoride supplements
☐	☐	Orthodontics or appliances	In general, what has the patient's past dental experience been? ☐ Good ☐ Average ☐ Poor		

MEDICAL HISTORY

Name of patients
Physician_____Clinic_____

YES	NO		YES	NO	
☐	☐	Is the patient currently under medical care? Reason(s)_____	☐	☐	Autism
☐	☐	Taking any medications? Name of Meds_____	☐	☐	Cognitive Delay, Functional age level_____
☐	☐	Ever had surgery or been hospitalized overnight? Reason:_____	☐	☐	Diabetes If yes: Medication?_____
☐	☐	Ever had a blood transfusion? If yes: Date_____/_____/_____	☐	☐	Epilepsy, Seizures If yes: Medications?_____
☐	☐	Tubes, Shunts, or Prostheses? If yes:explain;_____	☐	☐	Hepatitis or Liver disease/ exposure
☐	☐	Allergies; Latex, Food, Medications etc. If yes, please list_____	☐	☐	Heart Disease? If yes: ☐Murmur ☐Congenital Defect ☐History of rheumatic fever
☐	☐	AIDS/ HIV	☐	☐	If yes to Heart Disease, is a pre-med antibiotic required before dental appointments?
☐	☐	Asthma	☐	☐	Hearing Loss
☐	☐	Blood disorders ☐Anemia ☐Hemophilia ☐Sickle cell anemia ☐Other_____	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Learning disability
☐	☐	Cerebral Palsy	☐	☐	Measles
☐	☐	Chicken Pox ☐ recent exposure	☐	☐	Pregnancy
☐	☐	Behavior problems	☐	☐	Skin Rash
			☐	☐	Sinus Problems
			☐	☐	Thyroid Condition
			☐	☐	Tuberculosis or exposure to Tuberculosis

☐I am the parent or legal guardian for this child and I understand I will be financially responsible for any services rendered. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Stanton Allen, Dr. Brandon Nakken,and/or Dr. Brandi Oberg or any members of the staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Parent/ Guardian_____ Date _____/_____/_____